Testimony Against AB 710, the Abortion Procedures Ban

Submitted by Dr. Fredrik Broekhuizen
January 28, 2008

Dear Chairman Suder and Members of the Assembly Judiciary and Ethics Committee:

I am submitting this written testimony today in opposition to AB 710. I regret my inability to join the committee in person; however as a physician with a busy practice it is very difficult for me to rearrange my patient schedule on such short notice. In the future, I hope this committee will consider providing more than a week's notice so the physicians like myself who understand the complexities of medical issues can attend in person and provide you with the expertise this committee likely does not share. I hope this testimony will give you an important perspective regarding the devastating impact this bill could have.

I am a board certified obstetrician and gynecologist that has been practicing in Wisconsin for 32 years. I am also a professor at the Medical College of Wisconsin. I am the Medical Director of Planned Parenthood of Wisconsin. I take care of many patients with high risk complicated pregnancies. And I am one of the few providers of medically indicated pregnancy terminations in a hospital setting.

Last spring, in a devastating decision from the U.S. Supreme Court, the first ever federal abortion procedures ban was upheld and became the law of the land in this country. This ban, like AB 710, had no exception for a woman's health. This omission made the Supreme Court's decision extremely dangerous, as it was the first time ever that a court has said the government can outlaw certain abortion procedures without allowing for anyone to consider the woman's health. This travesty of our federal government should not be multiplied by the state of Wisconsin. The banned procedure in AB 710 is already illegal in Wisconsin and nationwide. I know this because the Wisconsin bill is an exact replica of the federal law. We must resist the temptation to put Wisconsin's rubber stamp on a law that makes it significantly more difficult to physicians to provide medically necessary services.

The bad policy behind this bill undermines fundamental trust that physician has with patient because it prevents physicians from giving the best possible care to our patients. In addition, fear of prosecution, conviction and imprisonment on the part of the physician caring for a woman will certainly chill woman's access to medically necessary services. Physicians who fear fishing expeditions by local authorities who will have power under AB 710 may stop providing crucial abortion care for women in Wisconsin altogether. This would be an extremely untenable position for Wisconsin that would greatly endanger maternal health in our state.

Second trimester abortions are a medical fact of life, the need for them will not go away—mostly because many of these pregnancy termination are done to preserve a woman's health in very dangerous and tragic situations. The procedure that is banned by the federal law and now AB 710 is very rare and almost never used in Wisconsin that I knew of. But in some of these extreme circumstances, it could certainly be one of the safest options available.

As an obgyn, my goal is always to provide women with the medical services that are most appropriate to her individual situation and that will best protect her health. In my practice of 32 years, I understand that dangerous health complications arise that can necessitate second trimester abortions to preserve the health of the mother.

In each of these situations, the risk to a woman's health may be less if the banned procedure were allowed. It is certainly unethical and unacceptable that this federal law, and now this bill, would insert politicians into the health care decision and trump concern for a woman's health in the state of Wisconsin.

Lethal fetal disease can cause situation that jeopardize the health of pregnant women and their future ability to carry a pregnancy with the least amount of complications. Under these tragic and unanticipated circumstances a D&X procedures (presumably the procedure that this law would ban) may serve the best health interests short and long term of the mother.

Finally, I believe it is very important to note that the American College of Obstetricians and Gynecologists (ACOG) vigorously opposes these bans. ACOG is a professional membership organization that has over 51,000 members nationwide, including myself. In addition, over 90% of all board certified obgyns are ACOG members, so this is a professional organization that represents the position of almost all obgyns in the U.S. It is ACOG's official position that states must not be allowed to outlaw abortion procedures. I urge you to consider my own personal experiences caring for women in Wisconsin and the majority opinion of most obgyns in this country. Please do not pass this bill out of committee.

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PREPARED REMARKS OF MICHAEL BOWEN
CONCERNING AB 710

Good afternoon. My name is Michael Bowen and I have come here to support AB 710, the partial-birth abortion bill that is currently before you for consideration. I have been associated with Wisconsin Right to Life for many years as the chair of its legal committee, but I am speaking to you this afternoon not as a representative of any organization but in a purely personal capacity, simply as a Wisconsin citizen. I very much appreciate your taking the time to hear and consider my remarks.

While I will be happy to try to answer any questions the committee may have for me, I intend to focus primarily on a narrow but important issue, namely: Why are we having this conversation? AB 710 closely tracks cognate federal legislation that has been upheld by the United States Supreme Court. With a federal law in place, why is it desirable or appropriate to adopt a substantially congruent measure at the state level? Isn't this, at best, wasted effort?

The answer to that question is no, just as it is in numerous other areas of the law, such as antitrust, trademark and unfair competition, and civil rights, where Wisconsin (along with many other states) has chosen to adopt legislation of its own to deal with issues that are also addressed by federal statutes. The reasons for the wisdom of this approach are straightforward.

Particularly in the criminal area, a law on the books is only as good as the enforcement effort deployed by the responsible authorities to ensure that that law is obeyed. Prosecutors have to decide which types of crimes and offenses will receive priority attention from their offices, which will be treated as lower priority matters, and which will be, for all practical purposes, overlooked altogether. Particularly in the case of federal laws, these decisions can reflect policy judgments made in Washington, potentially infected in some cases by partisan political

considerations, that may be quite foreign to the values, concerns, and interests of Wisconsin citizens. The reasons for not enforcing a particular law need not be invidious, although of course they may be. They can range from a mundane choice about resource allocation to a deliberate decision not to enforce a particular law because those in power at the moment do not agree with it.

State legislation on a given topic ensures that discretionary policy choices made at the United States Department of Justice will not necessarily be translated into a one-size-fits-all, made-in-Washington straitjacket limiting the protection of Wisconsin values by prosecutors and judges who have been elected by the people of this state for that purpose. With a state law in place in this area, a decision by the federal government that, say, substantially all federal prosecutorial resources will be devoted to combating drug dealing, organized crime, and illegal immigration would not mean that partial birth abortions could proceed with impunity. Wisconsin prosecutors elected by the people in their counties, in touch with the vital interests and concerns of those people and the communities they live in, would be in a position to fill any gap left because the federal government was distracted by other concerns or chose to turn its attention elsewhere. Washington's priorities would not automatically become our priorities. Wisconsin officials would retain not merely the theoretical right but the practical ability to take up the slack and to pursue a Wisconsin agenda in the face of federal inaction.

This is by no means merely a theoretical concern. Those of us of a certain age can vividly remember the 1960's, when the brutal murders of civil rights workers in some states would have gone completely unpunished because of the indifference and outright hostility of state authorities, if the federal government had not stepped in to pursue criminal prosecutions

under federal statutes that, in the limited area of racially motivated crimes, provided a means of attacking crimes that was parallel to state criminal codes.

While we all hope that those days are gone forever, we cannot ignore the possibility that analogous policy discrepancies will arise, in reverse fashion, in the partial birth abortion area. Although the condemnation of partial birth abortion enjoys broad bi-partisan support, both nationally and in Wisconsin, it is a highly charged political issue that a new administration in Washington may be reluctant, for a variety of reasons, to engage in the untidy arena of street-level, day-to-day, on-the-ground law enforcement. We are entitled to hope for the best, but we are required to plan for the worst; as I sometimes remind my colleagues, lawyers are paid to be pessimists.

It is for these reasons that I urge the committee's support of AB 710, and ask that it be reported favorably. Thank you for your attention.

January 31, 2008

Testimony Opposing AB 710

Good afternoon Chairman Suder and Committee members:

My name is Tosha Wetterneck and I am here today, as a physician, to express my strong opposition to AB 710, the Abortion Procedures Ban. I am a licensed physician in WI and have been practicing General Internal Medicine for 13 years. This bill is bad public policy on many levels. My understanding is that this bill's prohibition is already an appalling federal law—I see no valid reason why Wisconsin would want to follow this poor policy and send the message that physicians' expertise *and* their patients' health are subordinate to the will of extremist political agenda in Wisconsin.

This bill perpetuates bad public policy passed on the federal level. While state lawmakers cannot undo the poor decisions Congress has made, you can make a difference in protecting women's health in Wisconsin. By blindly following this extreme policy that prohibits certain second-trimester abortions, Wisconsin would not allow a woman, her family and her physician to consider the negative impact of a pregnancy on a woman's health when making health care decisions. Essentially, by doing this, Wisconsin would undermine the doctor-patient relationship. The threat of government interference in my relationships with patients is devastating. As a physician, I have an ethical duty to provide my patients with the best information I can for their individual situation. They trust me to take care of them and to help them make health care decisions that are in their best interest. If this bill passes, I know that patients may be less honest with me about their health conditions for fear of the legal consequences. And I greatly fear that patients may lose trust in my ability to care for them and to help them make decisions that are in their best interests. Laws regulating that flow of information and access to certain medical services threaten my professional autonomy and will compromise patient care. It is highly inappropriate for Wisconsin legislature to begin down that road.

I believe bills like this regulating a physician choice in patient care come very close to an unlawful practice of medicine by the state legislature. I have dedicated much of my life to becoming a physician. I spent 4 years in medical school and 4 years in Internal medicine residency in Wisconsin and I have spent an additional 13 years caring for patients in the state of Wisconsin and attending classes and conferences to continually hone my skills as a physician. I am always working to ensure that I have the most updated information and access to advancing medical technology for my patients. It is deeply insulting that this body would assume that it is more qualified than physicians like me to determine which medical procedures are most appropriate for any patient. Physicians are trusted to take care of patients' health for a reason. State legislatures are not equipped to care for patients and should not be in the business of dictating health care decisions.

Finally, I just want to note that if this legislature is serious about reducing abortions in Wisconsin it should stop playing these political games with women's health. Preventing unintended pregnancies by providing better access to birth control and sex education is really the only way to decrease the number of abortions. A bad bill like this does nothing to curb abortions. I urge you to reject political efforts that only result in undermining the medical profession in Wisconsin and instead focus on providing patients with the access they need to preventative health care.

Thank you.

WISCONSIN CATHOLIC CONFERENCE

TESTIMONY REGARDING ASSEMBLY BILL 710:
PARTIAL BIRTH ABORTION
Presented to the Assembly Committee on Judiciary and Ethics
January 31, 2008

My name is Barbara Sella and I am the Associate Director for Respect Life and Social Concerns at the Wisconsin Catholic Conference. On behalf of Wisconsin's Roman Catholic bishops, I urge you to support Assembly Bill 710, which would bring Wisconsin's law on partial birth abortions in line with federal law.

As Catholics, we try to evaluate every public policy in light of its impact on the human person. And we strive to do this in a way that is consistent. Thus, we oppose the death penalty, assisted suicide, euthanasia, and abortion.

Each of these four forms of killing have their defenders, who claim that at certain critical times, the life of one human being may have to be sacrificed for the good of another. In the case of abortion, pro-choice advocates generally concede that a human life is in the womb, but that this life has fewer rights than those of its mother.

This simply does not stand to reason. In a democracy such as ours, we uphold the principle that we are all created equal, and endowed by our Creator with the right to life, liberty, and the pursuit of happiness. Mother and child share these fundamental rights. Rather than destroying the child in order to uphold the mother's right to liberty and the pursuit of happiness, we need to look for different ways to uphold the rights of both.

We do not close our eyes to the suffering and despair of women who are facing an unwanted pregnancy. In fact, it is precisely in helping women that we can best help their unborn children. In addition to rethinking labor, urban, residential, and social service policies to create a society where it is possible to bear and care for children, we need to change our abortion laws, so that when a woman is faced with an unplanned pregnancy, she will not feel the subtle pressure and temptation to kill her unborn child. We simply cannot accept the contention that a woman cannot advance unless she is at liberty to abort her children.

The Church is also not blind to the plight of pregnant women whose lives are truly in danger. The Church recognizes that in some rare instances, where a mother's life is truly at risk, the death of her unborn child is tolerated if it happens as an unintended consequence – and an indirect result – of providing her with non-abortive operations, treatments, and medications that have as their direct purpose the cure of her serious medical condition.

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As you deliberate on this bill, you may wrestle with the question of whether it is appropriate to limit the ban to just this procedure, and whether to allow for a "life of the mother exception." Although this bill does not ban all abortions, we believe a vote for it is justified.

Even though the Church's teaching on the matter is clear – abortion is never permissible – in his encyclical, *The Gospel of Life*, Pope John Paul II counseled that "when it is not possible to overturn or completely abrogate a pro-abortion law, an elected official... could licitly support proposals aimed at limiting the harm done by such a law and at lessening its negative consequences at the level of general opinion and public morality."

The pope added, "This does not in fact represent an illicit cooperation with an unjust law, but rather a legitimate and proper attempt to limit its evil aspects."

Based on this teaching, the Wisconsin Catholic Conference recognizes that state lawmakers must exercise prudential judgment to determine at this place and time in history what is realistically attainable in crafting a law that bans or drastically limits partial birth abortions.

Today, we can see more clearly than in 1973 the consequences and the limits of an unchecked "right to choose." An estimated 90 percent of fetuses diagnosed with Downs Syndrome are aborted. A growing number of married couples are experiencing infertility, and yet cannot adopt domestically, in part because of the high rate of abortions. In other parts of the world, the number of aborted females has reached critical proportions.

Banning partial birth abortion brings us closer to the day when these practices will no longer be acceptable. We respectfully urge you to support Assembly bill 710.

Thank you.

PLANNED PARENTHOOD ADVOCATES OF WISCONSIN

TESTIMONY OF PLANNED PARENTHOOD ADVOCATES OF WISCONSIN IN OPPOSITION TO AB 710
THE ABORTION BAN

My name is Chris Taylor and I am the public policy director for Planned Parenthood Advocates of Wisconsin. I appreciate the opportunity to testify before this committee today and provide the perspective of the largest and oldest family planning provider in Wisconsin. Planned Parenthood Advocates of Wisconsin strongly opposes AB 710, the Abortion Ban.

Planned Parenthood has a keen interest in making sure that no patient experiences an unintended pregnancy, and we do everything within our power to provide our patients with the direct clinic services and education so that this is avoided. Each year, we serve over 70,000 patients throughout the state by providing breast and cervical cancer screening and cervical cancer treatments, sexually transmitted infection testing and treatment, pregnancy counseling and access to birth control methods, and abstinence-based, age-appropriate sex education. We also are one of only three abortion providers in the state of Wisconsin, providing abortion services in Appleton and Milwaukee.

This bill is almost identical to the Federal Abortion Ban, which bans the very same procedure in every state in the country. To be clear, the abortion procedure that is at issue in the state bill is already banned.

This abortion ban was twice vetoed by President Clinton during his presidency because it did not have an exception for a woman's health. President Bush unfortunately signed another federal abortion ban in 2003. Though this ban had a life exception, it had no health exception. Planned Parenthood, along with other women's health care partners from across the country, litigated this case all the way up to the U. S. Supreme Court, arguing that this ban must have a health exception. For the first time in 34 years, the U.S. Supreme Court decided that an abortion ban did not have to have an exception to preserve a woman's health. As a result, this terrible and dangerous ban is unfortunately law of the land. The only exception is when a woman's life is threatened. What this means is that physicians are prohibited from using the safest abortion method to preserve a women's health. I ask the proponents of this bill, if this procedure can be used to save a women's life, why not to preserve her health?

The Supreme Court's decision was indeed shocking after the nearly five years of litigation preceding it. Several federal district courts heard vast quantities of evidence on the devastating impact this ban could have on women's health in America. The vast majority of the evidence presented by numerous experts in the fields of obstetrics and gynecology and on behalf of the nation's largest professional medical organizations demonstrated how dangerous this abortion ban could be for a woman's health. Physician after physician testified under oath on how dangerous pregnancy becomes when the government inserts itself into the doctor's office and actually forbids a physician from considering a woman's health and using the safest abortion procedure in the most tragic pregnancy situations.

While we cannot immediately change the Bush Administration's poor decision making and disregard for women's health—today we do have the opportunity to ensure that Wisconsin does not blindly follow this dangerous Bush policy.

Your actions today will not alter current law as we already have this very policy in place today that prevents doctors from using medical procedures that are in the best interest of a woman's health. Rather, your actions today will underscore whether you stand with the Bush Administration and its blatant disregard for women's health; or do you stand for the women of Wisconsin, those of us who often have to make complex and untenable decisions about our families, pregnancies and our health and lives?

There are real women and families every day, in Wisconsin and nationwide, who deal with difficult gut wrenching decisions when it comes to pregnancy and childbearing. Even for an otherwise healthy woman, pregnancy is risky. According to the World Health Organization, up to 15% of pregnant woman in the world experience potentially fatal complications from pregnancy—that is over 20 million women a year. Between 12% and 27% of all women are hospitalized sometime during pregnancy. Some common health problems that can complicate a pregnancy include:

- Uterine scarring from prior c-section or other abdominal surgery
- Bleeding disorders
- Pulmonary disease, including asthma
- Preeclampsia—dangerously high blood pressure caused by pregnancy
- Placenta Previa—a condition where the placenta attaches to the uterus on top of the cervix
- Uterine and fetal infections

For many women, these risks become greater as pregnancy progresses and their lives, their health and future fertility are often put in danger.

Some women have pre-existing conditions that make a pregnancy extremely dangerous. Conditions like uncontrolled diabetes, primary pulmonary hypertension, congenital heart disease and thyroid hyperfunction or hypofunction greatly increase the risks associated with pregnancy. In addition, diseases like cancer or epilepsy that require medication or chemotherapy create a greater risk for women who become pregnant.

As stated by the American College of Obstetricians and Gynecologists (ACOG), the leading women's health organization in the country that represents over 90% of practicing ob/gyns, in their legal brief opposing the federal abortion ban, "the safety advantages of the banned abortion procedure are particularly significant for women who suffer from serious medical conditions." ACOG goes on to say that the federal ban "prevents physicians from providing the care that is most likely to avoid potentially catastrophic health outcomes."

And then there are women who experience pregnancies that unexpectantly go terribly wrong. For these women, pregnancy termination is a decision they face to preserve their health and lives. Christine G is one of these women who was faced with this decision after carrying her pregnancy into her second trimester. These are her words:

> In March of 2002 early in the 2nd trimester of my 4th pregnancy, I started to experience bleeding which landed me on bed rest for the remainder of the month. Despite an ultrasound that indicated nothing was wrong and extreme care during the month, on March 27, 2002, my water broke.

At this point I was toward the end of my 18th week of pregnancy and felt very much connected to my son. He had been kicking me vigorously all month and even my 18 month old daughter understood that a "baby was in mommy's tummy".

Unfortunately, when one's water breaks this early in a pregnancy both the mother and baby are doomed unless action is taken. Infection that can be fatal to both sets in quickly, often within 24 hours. My husband and I were informed that we had the option of placing me in a secure isolation chamber to ward off infection so as to continue the pregnancy, but we were also informed that even in the extremely rare case my body could continue to support the pregnancy, our son had virtually no chance.

Since amniotic fluid is critical for lung development, babies born to women who have prematurely ruptured their membranes (PROM) usually have severe breathing problems and short lives. Live births PROM cases have only been documented in pregnancies lasting far longer than 18 weeks. In my case, the attending doctor relayed that a live birth was really only "theoretically" possible and that given the risk of infection to me, he would not advise attempting to continue the pregnancy.

Despite our grief at the impending loss of a 3rd pregnancy, especially so late, we came to the conclusion that moving to the isolation chamber was not the best option and that we would let nature take its course. We did not fully understand at the time that letting nature take its course would result in both my and my son's death. Instead we had to decide whether or not to actively induce labor or schedule a dilation and extraction procedure (D&E). We were advised to do one or the other quickly so as to avoid the infection that would most certainly come.

Although it was only one day/night, it seemed like an eternity of consideration. My husband and I decided that we would induce labor. We weighed absolutely everything in this decision including the impact on my daughter, the potential trauma for our son (who at that point was still kicking strongly), my health and safety, as well as the emotional trauma of a drawn out ordeal. Eventually, even though we knew our chosen option was 1) less "safe" in regard to my own health, 2) more painful for me, 3) required a longer hospital stay and 4) my son would be stillborn, I wanted a chance to hold my son and say goodbye in person.

As I'm sure you can imagine this was a very traumatic event in my life. I made decisions during that last week of March 2002 with my husband and in consideration of our family. We felt that despite our strong connection to our unborn son, we needed to make decisions for the future and in the interest our strong and healthy 18 month old daughter who needed her mother.

It isn't easy to make a decision to induce labor that you know will result in the death of your baby and it doesn't come lightly. Whatever your decision in this circumstance, it is extremely difficult.

Know that women who make decisions to terminate a pregnancy, especially into the 2nd trimester do not come to their decision lightly. As practicing Catholics we actually considered whether or not we should let "nature take its course" and then decided that my life and the need of our daughter to have her mother were more important than betting on a miracle.

We have our son's framed footprints in our living room and I have saved his hospital blanket along with other mementos from that pregnancy. He has a memorial tree in a national forest, and donations are made annually in his name. Benjamin was my son and yet I chose to take

a course of action that would prematurely (granted only by a couple of hours) end his life because it was the best option for my family. Please don't insult me and other women like me (or unlike me for that matter) by assuming that we don't already consider absolutely everything, including things you could never even imagine to legislate about, in making such an impossible decision.

Please don't tell us and our families, that our health doesn't matter. We need to be told everything, to be given ever option available. And then we, with our families, need to make the decision.

If the Wisconsin Legislature does follow the Bush Administration and adopt this terrible ban, what you are saying to Christine, to her husband, to her 2 children and to her family is that her health doesn't matter. That is what you are saying to every woman in Wisconsin. I would surmise that any of you that found yourself in a similar situation to Christine would certainly want the health care provider caring for your loved one to consider her health, and to give her a choice as to what course of action to take, including the safest abortion procedure available. In fact, each of you sitting around this table would want that health care provider to do everything within his or her power to protect your loved one's health.

Bans like AB 710 that tell physicians that they cannot consider a patient's health when making treatment decisions are simply unconscionable. All of you had an opportunity last week to enhance women's access to birth control through supporting the Compassionate Care for Rape Victims bill (AB 377). Disappointingly, many of you who support this bill, voted against even granting rape victims enhanced access to birth control to prevent pregnancy and the incidence of abortion following assault. In opposing Compassionate Care for Rape Victims you denounced that bill as the height of political interference into the medical profession, even though that bill merely codified an accepted standard of care imposed by the medical profession itself. This Abortion Ban actually makes it a crime for a physician to consider a woman's health even in the most egregious, tragic pregnancy situations. Talk about the height of political interference into the practice of medicine.

This bill is also medically unethical. Indeed, the Wisconsin medical code of ethics directs physicians to place a paramount importance on a patient's life and health. Any action that places a patient's health in danger would violate the professional code. Wis. Admin. Code MED 10.02(h). Further, the American Medical Association's Principles of Medical Ethics states that physicians must "recognize responsibility to patients first and foremost." This bill directly contradicts accepted medical standards of care and ethical principles that form the foundation for the practice of medicine.

Instead of wasting precious legislative time debating an abortion procedures ban that is 1) already federal law and 2) extremely poor public policy, this body should refocus the debate on decreasing unintended pregnancies. It is absolutely clear that this abortion ban will not stop one abortion in Wisconsin—one point that PPAWI and extreme abortion opponents like Wisconsin Right to Life and Pro-Life Wisconsin probably agree upon. It will only denigrate the physician-patient relationship in Wisconsin and force women in tragic situations to undergo riskier pregnancy terminations. Instead of passing this bill, throwing women's health out the window and pandering to the political extremes, I urge you to work with Planned Parenthood and the public health community to increase access to birth control and sex education—the only proven way to reduce unintended pregnancies and the abortions that result.

In the meantime, I ask that you vote against this bill. A woman's health should matter in Wisconsin.

Thank you.

private lives

When **Lori Campbell's** second pregnancy developed complications, she was faced with a painful decision. But she was thankful it was hers to make.

JOYRIDE
THE AUTHOR WITH DAUGHTER CHARLIE, SIX, NEAR THEIR GREENWICH VILLAGE HOME. CHRISTOPHER FISCHER CARDIGAN. Y & KEI CAMISOLE. J. CREW SKIRT. DETAILS SEE IN THIS ISSUE.

KEVIN STURMAN. Sittings Editor: Lisa Mosko. Hair, John Ruidant for Cutler NYC/Redken at See Management; makeup, Sara Glick for Jurlique.

Last year, when I was 43, I was convinced I was pregnant. I'd been pregnant four times before and knew the early signs well—cramping, nausea, and a general feeling of queasy excitement. After a few days I went to the drugstore, bought a pregnancy test kit, ran home, and did the test right away. It was negative. Of course it was negative! My husband, Ian, had been traveling. We'd been using contraceptives. I was 43! What was I thinking?

What surprised me most was that by the time I returned home from the drugstore, not-yet-taken pregnancy test clutched in a slightly sweaty palm, I already had feelings for the baby. No matter that nothing was confirmed; I had a hunch, and that was enough to put me into full-on mother-to-be mode: protective yet giddy, serious yet over the moon. That single line—not pregnant—took my breath away. I realized then how much we are hardwired to love our children at every stage of development: child, toddler, baby, fetus, embryo, zygote, and even potential zygote. I stared at the stick in my hand, at that pink "I was almost a baby, but I wasn't" stripe, and it thrust me back into the past—to the four times the test was actually positive.

Four chances at the ineffable thrill of giving life, four entirely different outcomes. My first pregnancy ended in an early miscarriage. The third resulted in a healthy baby boy, now eight years old, and the fourth a healthy baby girl who is now six. But the second pregnancy was quite unlike the others. It took my husband and me on a journey for which nothing in life had prepared us, one a person can only fully understand once they live through it.

In the summer of 1998, Ian and I rented a small house on the beach in Montauk, New York, and were happily, yet cautiously, preparing for our first child. We were cautious not just because my first pregnancy had ended in miscarriage but also because the miscarriage had floored us in a way neither of us expected. We were heartbroken. We'd gone from trying to get pregnant to ecstatically being pregnant to "Can we or can't we have a baby?" I was 34, and Ian was 38. We struggled to find the balance between accepting our loss and recapturing our optimism. A few months later I was pregnant again.

During my second pregnancy, it wasn't until we were past the "danger zone," at a full five months, that we started to breathe a little easier. We'd had an amniocentesis at sixteen weeks, the results were good, and we found out we were having a girl. We took turns feeling the baby kick and talking to her. We'd nicknamed her Bean. Then, in the middle of one hot August night, when I was about 22 weeks along, I suddenly woke up to the feeling of gushing fluid. I went to the bathroom, *up front >68*

A MOTHER'S HEARTBREAK

and the liquid kept flooding out of me. In my half-awake stupor, the dreaded realization dawned on me: My water had broken. I woke Ian, and we drove straight to the emergency room. We were admitted into the hospital's maternity ward, where we would spend the next five days, during which time many doctors would examine me and the baby and guide us through an extraordinarily difficult decision—one ultimately made not by a doctor but by a husband and wife, alone.

Viability. Anatomical threshold. NICU. Words that had little or no meaning to us a day earlier were now the focus of our lives. We were told I'd most likely go into labor within seven days, so we had to learn fast. First we met with the head of the hospital's neonatal-intensive-care unit (NICU). A straightforward man in his mid-50s, he did not sugarcoat the situation. The threshold of viability, or the earliest a fetus is potentially able to live outside the womb, is generally accepted to be around 25 weeks. (This statistic has remained relatively constant over the past decade.) Mostly because of the immaturity of their lungs, babies born before this time cannot survive, even with assistance. They are too small, often weighing between 500 and 650 grams, which is little more than a pound—the weight of a pint of water, four sticks of butter.

Doctors, nurses, relatives, friends, spiritual advisers—we had many visitors in the hospital. But one thing never entered the room: politics

Our case was also reviewed by the hospital's head of pediatrics, who presented us with some statistics: In a study conducted in 1995, there were 138 live births at 22 weeks. Roughly 84 percent died in the delivery room, 14 percent in intensive care—a 1 percent survival rate, with almost guaranteed severe disabilities, such as brain damage. Our baby was now just over 22 weeks. The doctor also confirmed that I'd probably go into labor in the next few days, but he was the first to say there was a slim chance I wouldn't. The baby could possibly continue to grow, despite its limited pool of amniotic fluid. I might make it to 23 or 24 weeks. With a miracle I'd get to term. No one could say for sure.

One floor below us was the NICU, and we were given a tour. The smallest baby in an incubator at the time was just over 24 weeks. An umbilical catheter, or feeding tube, protruded from its stomach, a ventilator pumped air into its lungs, and it could not be held for fear of tearing its skin. The baby's temperature, heart rate, and oxygen were monitored, and, as if there were no other place to put them, IV's were attached to its feet. Ian and I faced the grim realization that our baby would need at least two more weeks in the womb just to get to this point.

Our obstetrician, a well-loved doctor in his late 40s with four children of his own, asked us to look toward the future. He said that my water had broken prematurely because of a condition called incompetent cervix. In a normal pregnancy, the cervix remains firm and closed until a woman reaches term, around 40 weeks. But with an incompetent, or weakened, cervix as the baby grows and begins to press down, the cervix starts to open prematurely, often causing the membranes surrounding the amniotic fluid to rupture. Incompetent cervix affects roughly one in 100 women and is the cause of about 25 percent of miscarriages between 18 and 22 weeks.

Our OB recommended we terminate the pregnancy as soon as possible. The good news, he said, was that next time I got pregnant he would stitch the cervix closed with a cerclage, a strong thread sewn around it to reinforce it and help keep it sealed. With a few months of bed rest during the pregnancy, he felt confident everything would be fine.

But how to look toward the next baby when the one inside you is twisting and turning, each jolt of an elbow or foot shouting, I'm alive and kicking! No wonder Ian and I desperately listened to the well-intentioned, optimistic stories that poured in from friends and relatives. "My neighbor's sister's cousin had a 23-weeker and it lived, it's doing OK; I think there's something wrong with its eyes. Or was it 24 weeks? Anyway, their doctor said there was no chance, too."

We couldn't have wished harder for the baby to survive the odds. Since the moment we arrived at the hospital, we were surrounded by a cacophony of baby-monitoring sights and sounds, their unintentional effect to make us know and love our unborn baby even more. The baby's heart was constantly monitored, each blip in full view on a screen next to my bed. Every day I was carefully placed on a stretcher to prevent me from leaking any more amniotic fluid and wheeled off for a fetal sonogram. The baby's weight was taken (400 grams the first day, 410 the next).

They measured the amount of amniotic fluid to see if on the outside chance the ruptured membranes had resealed and the fluid was reaccumulating. It wasn't. And during all this somber talk of low weight and fluid amount, there she was for all the world to admire, the star of her own gymnastics show on a black-and-white TV with bad reception. Bean. We searched every single doctor's and nurse's eyes, body language, and words for hope. By the third day and the third sonogram, I could no longer bring myself to look at the screen. Doctors, nurses, relatives, friends, spiritual advisers—we had many visitors in the hospital during those few days. But one thing never entered the room: politics.

In 1998 the term *partial-birth abortion* was hardly on anybody's radar, and certainly not on ours. The term is a political one, not a medical one, and was coined by the National Right to Life Committee in the mid-nineties. The phrase describes a procedure called intact dilation and extraction (intact D & X), typically used in pregnancies between 20 and 24 weeks. It is considered by many doctors to be the safest way to remove a fetus this age from the womb because it reduces the risk of uterine tearing, thereby increasing the chances for the woman to deliver healthy babies in the future. Bill Clinton had twice vetoed a law banning "partial-birth abortion," in 1996 and 1998, which would have made it a federal crime for a physician to perform the procedure unless it was necessary to save the life of the mother. In 2000, the Supreme Court struck down a Nebraska statute banning partial-birth abortion because it lacked an exception for the health of the woman, but President Bush signed a revised version into law in 2003. Though the new law faced numerous challenges, the phrase itself has gained steam and become a powerful tool in the antiabortion movement's "chipping away" strategy. Rather than simply divide the population into two *up front* >69

A MOTHER'S HEARTBREAK

segments, pro-life and pro-choice, the new tactic is to ban the most unpalatable abortion procedures and then work down toward the ones commonly performed during the first trimester.

The strategy seems to be working. The Supreme Court's recent decision, in April 2007, to uphold the Partial-Birth Abortion Ban Act is widely expected to be the first of many victories for the antiabortion movement to erode the choices that currently can be made in private between a family and their doctor. Essentially, it gives a green light to individual states to outlaw the procedure. The American College of Obstetricians and Gynecologists (ACOG), which represents about 90 percent of all ob-gyn specialists in the United States, is one of many major medical organizations opposed to the ban, stating in its literature that "the intervention of legislative bodies into medical decision making is inappropriate, ill-advised, and dangerous."

The propagation of the phrase *partial-birth abortion* is in itself a victory for conservatives. It is designed to evoke the gruesome imagery of a baby killer. Today a woman or couple who face the devastating decision to abort a pregnancy in the second trimester have this expression, this visual image, and this ideology weighing on them, and for many that will be enough to dissuade them from going through with it. I have no doubt that if the terminology had been a part of the lexicon a decade ago, our ordeal would have been much more difficult. Our doctors euphemistically referred to the procedure as "the procedure." We debated only whether to have "the procedure" or not to have "the procedure." In light of the recent Supreme Court decision, I see what a blessing the freedom, privacy, and support were.

To the men who would force women to deliver a baby who will be born very sick and die, all I can say is, You cannot know

Every doctor who recommended I go through with "the procedure" treated my life and the life of my baby with the utmost respect, honored my right to choose, and wholeheartedly supported my decision. Men, all of them. None who dared tell a woman what to do.

The term *partial-birth abortion* is also inherently judgmental. How can I agree to a partial-birth abortion and not feel like a bad person? It preys on women in a weakened state—women who already likely believe they are "bad" because they have failed as mothers. In my case, an incompetent cervix threatened the life of a fetus otherwise healthy and so close to meeting the world. All she needed was another lousy couple of weeks, I kept telling myself. But I had failed her. My incompetence, I felt, extended well beyond the cervix into every fiber of my being. I didn't need another person, or the government, to confirm it.

When Chief Justice John Roberts and the other men on the Supreme Court voted to uphold the ban this past spring, I couldn't help thinking, They cannot know what they are doing. In a way, it reminded me of when I tell my eight-year-old son to stop wrestling with his buddies. What is it with the wrestling and the testosterone and boys? I can watch it, study it, cogitate on it, but I don't know. Never will. The way that men can never fully grasp what it's like to be pregnant—surging hormones, pizza at 4:00 A.M., euphoria after delivery. Even my husband, a ten on the "sensitive guy" scale, a man who never left my side for those five days, holding my hand, my belly, my head—he doesn't know. He can't. To the men who would force women to deliver a baby who will be born very sick and die, all I can say is, You cannot know.

And yet a woman's right to choose may be further jeopardized by Supreme Court vacancies looming in the near future. Justice John Paul Stevens is now 87, and all three other liberal justices who sit on the court now will be 69 or older by November 2008. Which makes the stakes for this next election huge. Our next president will most likely appoint several new justices, who will serve for decades to come. Just one more conservative appointment to the court presents the very real threat of *Roe* v. *Wade* itself being overturned. Given the court's recent ban on so-called partial-birth abortion and the determination of conservatives to keep chipping away, abortion will likely be a more urgent issue for voters, who are now asking themselves, "Can I vote for a conservative for say, economic reasons, when a Republican president in 2008 could translate to the loss of all of my reproductive rights?" Our nation is at a crossroads. Will 35 years of the right to choose be replaced with 35 years of abortion's once again being illegal? For many people, the Supreme Court's recent decision has been a wake-up call to make sure this doesn't happen.

There are women faced with my situation who will want to deliver the baby even though they know it will die. There are women who will want to consider it "a late miscarriage" and move on. At the end of the five days, my husband and I knew which category we fell into. It is sad and tragic and one inhabited by thousands of couples who learn their baby has a fatal heart defect or brain disease, or is otherwise seriously compromised. We knew what we were going to do. It was just the doing part that seemed impossible. How do you pick up the phone, call your doctor, and tell him that they can come and take this kicking, thriving fetus out of you? How, literally, do you pick up the phone and make the call? The phone by my bed was covered in barbed wire, poisonous snakes, and an electric fence. I could not put my hand near it.

Beat-beat-beat went the heart monitor. Up and down it drew the lines. With every beat, a sign of life and a reminder that once the baby was born she would suffer and then die. Most likely for minutes, but possibly for days, weeks, years. In order to make the call, I needed to accept that what happened was not my fault, to believe that I wasn't a bad person. I think I actually said the words out loud. Only when I forgave myself for something I couldn't control could I find the strength to control what happened to the baby from here on out. How much or how little suffering she would endure—that was a decision I could make.

I chose what I believe was the path of least suffering, for myself, my husband, our future children, and mostly for the baby inside me. A partial-birth abortion, if you must call it that. One born out of love. □

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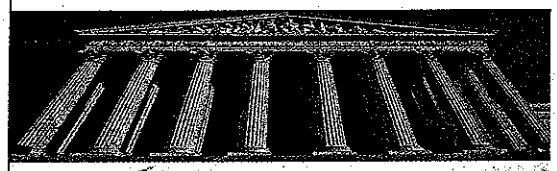

A MOTHER KNOWS BEST

When a 38-year-old woman discovered her pregnancy had gone horribly wrong, she had to make the hardest decision of her life

At 38, she was the happily married mother of a three-year-old. Eager for a second child, she and her husband were thrilled to learn that she was expecting twins. The first five months of the pregnancy were fine, but then an ultrasound revealed that one fetus had died. The other was still alive, but its head was grotesquely enlarged.

"This doesn't look good," the doctor told her. But there was a remote possibility that the brain swelling might subside, so he asked his patient to wait a week before deciding what to do. "That was the absolute worst week of my entire life," says the mother, who agreed to tell her story anonymously. The woman spent the week in seclusion with her family, praying. The fetus' condition did not improve.

She then faced a stark choice: end the pregnancy or spend the next four months carrying a doomed fetus and the decaying corpse of its sibling. She finally decided on what opponents of the procedure now call a partial-birth abortion. "I knew this was the right thing for the baby," she says. "There was a slim possibility that he could survive until delivery, but he would have died."

The procedure was harrowing. "I could hear everything, feel everything," she says. "They were talking about getting body parts. I had nightmares afterward." She nonetheless strongly believes that she made the right choice. "Nobody would do this out of 'convenience,' just because they changed their mind," she says. "It seems to me that only a man could say that. My mother has always been pro-life, but there was no question for her that this was the right thing to do."

The woman, who later had a healthy second child, was "shocked and furious" about the recent Supreme Court decision. "I can't imagine a politician being able to say, 'You've got to carry this baby to term,'" she says. "That a stranger would have the power to interfere in the hardest time in my life—it's unthinkable."—LESLIE BENNETTS

Testimony on the Wisconsin Partial-Birth Abortion Act
By Senator Scott Fitzgerald, 13th State Senate District

Assembly Committee on Judiciary and Ethics
January 31, 2008

Mr. Chariman and committee members, thank you for the opportunity to present testimony in support of AB 710, the Wisconsin Partial Birth Abortion Act. I join with my co-authors from the Assembly–Representative Jim Ott and Representative Tony Staskunas–in asking for your thoughtful review of this important legislation and your support in moving this bill to the floor of the Assembly.

First, I would like to provide some history on the Partial-Birth Abortion Ban and how we got to where we are today. During the 1997-98 Wisconsin legislative session, Representative Tony Staskunas and I co-authored legislation (SB 131/AB 220) that banned the partial-birth abortion procedure. 1997 Wisconsin Act 219 was signed by then Governor Tommy G. Thompson on April 29, 1998. The law was then challenged in federal court. Eventually, the Wisconsin ban was enjoined with several other states that passed partial-birth abortion bans which were ruled unconstitutional as a result of the 2000 U.S. Supreme Court Decision in *Stenberg v. Carhart.*

As a result of the recent *Gonzalez v. Carhart* decision on April 18, 2007, we are introducing a revised bill to ban the partial-birth abortion procedure in Wisconsin. The U.S. Supreme Court decision in *Gonzalez v. Carhart* upheld the federal Partial-Birth Abortion Ban Act of 2003. Upon review this ruling, Speaker Huebsch and I requested an opinion on the impact of the recent ruling upon Wisconsin's existing partial-birth abortion ban that was rendered unenforceable because of the Supreme Court's decision in 2000. The Attorney General's response suggested that our existing ban could not be reinstated because it did not mirror the federal ban which was more narrowly defined.

As a result, I have joined with my co-authors to draft the Wisconsin Partial Birth Abortion Ban Act. This legislation for the State of Wisconsin mirrors the language of the federal law, which can be found at 18 USC 1531 of the United States Code that was upheld by the US Supreme Court.

The federal ban makes the performance of a partial-birth abortion illegal throughout the United States. Even though there is now a federal ban in place, there are important reasons why a parallel state ban is necessary. With just a federal ban, prosecution of partial-birth abortion cases would only be handled by federal prosecutors. Prosecution of partial-birth abortion cases are best handled when state and local prosecutors each have the tools they need to ensure that the ban on partial-birth abortions is expeditiously enforced. A parallel state ban is essential to allow state and local prosecutors to become involved as well.

Diane C. Reis
dcreis@wisc.edu

Testimony opposing AB 710

Representative Suder and Assembly colleagues:

My name is Diane Reis and I am a medical student at the University of Wisconsin. I am here today in two capacities: as a future physician who may one day have to counsel a woman as she faces a dangerous pregnancy and as a friend who has supported and cared for a woman as she made this decision.

Last year my friend "Karen" became pregnant. Though she and the baby's father, Nate, were not married, Karen was ecstatic. She had been told a few years earlier that she would probably never be able to conceive. She and Nate were engaged and Karen eagerly planned for maternity. It was not an easy pregnancy. She had morning sickness that lasted all day, but she and the baby both seemed reasonably healthy until last March. Without warning, Karen began to cramp and bleed at work. She went to Meriter hospital where imaging revealed that the placenta was separating from the wall of her uterus. She was in the hospital for six days.

Two weeks later, when she went for her 20 week ultrasound, it was immediately clear that there was not enough amniotic fluid. She was told that they would wait for two weeks and do another ultrasound and that she was probably leaking amniotic fluid. If the situation improved at all, she would try to carry the pregnancy to 24 weeks and then take steroids to speed the baby's growth. If not, she was left with a difficult choice: end the pregnancy by having an abortion of the sort that would be outlawed by this law, or wait and hope that when the baby inevitably died, it would deliver on its own. The later option would put her at risk of hemorrhage, serious infection and sepsis, and further reduced chances of ever carrying a pregnancy to term. As a Catholic and as a concerned mother, Karen was torn. She and Nate talked and cried and finally decided that if the ultrasound revealed that indeed the situation had not improved, they would terminate the pregnancy to protect Karen's health and perhaps her life. Her doctor spent hours answering every question imaginable. In the end, their choice was not between two lives – with the amniotic fluid levels during the ultrasound, the chance of a live birth was essentially zero. It was to protect hers, using the best medical knowledge available.

If this law were to pass, both Karen and her doctor would have been trapped in an untenable Catch-22. Karen would have to choose between risking her life and health, breaking the law, and other methods of late term abortion that almost no providers are comfortable performing. Her doctor would have to choose between fulfilling the oath she took to protect her patients and offer them the best medical knowledge and treatment available and risking civil and criminal penalties and disregarding this oath, breaking the central covenant of the physician-patient relationship.

No woman wants to make the choice that Karen made. No doctor enjoys delivering the news that ends the joyous planning and leads to mourning and grief. This choice weighs heavily on the hearts, minds, and souls of both doctor and patient. There is, however, one thing worse than having to make this choice, and that is not being able to do so. I urge all of you to leave this terrible choice where it belongs: between a woman and her doctor.

Testimony of Elizabeth Shadigian, M.D. before the Wisconsin State Assembly, Committee of Judiciary and Ethics
Wisconsin Assembly Bill 710
January 31, 2008

Introduction

My name is Dr. Elizabeth Shadigian, and I am speaking today as a physician, scientist and educator in support of the mother's life exception (rather than a health exception), as part of the Wisconsin Partial Birth Abortion Ban. I was retained by the United States Department of Justice as an expert witness in the litigation challenging the federal Partial Birth Abortion Ban Act of 2003. I have also testified in other matters before the United States Senate and House of Representatives committees.

Background and Credentials

I have submitted to the committee a recent copy of my Curriculum Vita. I graduated in 1985 from Purdue University with a B.S. in Chemistry. I received an M.D. degree from Johns Hopkins University School of Medicine in 1990 and completed my Obstetrics and Gynecology residency at Franklin Square Hospital Center in 1994, both in Baltimore, Maryland.

I am currently in private practice in Ann Arbor, Michigan and am Adjunct Clinical Associate Professor of Obstetrics and Gynecology at the University of Michigan, where I worked full time for over twelve years from 1994 through 2005. I have been board certified in Obstetrics and Gynecology since 1996 and am licensed to practice medicine in the State of Michigan.

I am a Fellow of the American College of Obstetricians and Gynecologists (ACOG) and President of one of ACOG's largest special interest groups, the American Association of Pro Life Obstetricians and Gynecologists (AAPLOG).

My Statement of Opinions as an expert witness for the United States Department of Justice

1. In the absence of any published peer-reviewed medical studies evaluating the indications and complications of the D&X procedure, there is no sound basis for concluding that the D&X procedure offers safety or other clinical advantages over alternative abortion methods.
2. It is never medically necessary for physicians to perform partial-birth abortions in order to properly treat pregnant women suffering from high-risk medical conditions.
3. Medical induction is a safer abortion procedure than D&X.
4. Once a pregnancy reaches mid to late second trimester, medical induction is the safest method of performing an abortion.

Other Summaries

Additionally, my testimony and the testimony of other experts in the litigation surrounding the Partial Birth Abortion Ban Act of 2003 was summarized in the AAPLOG brief written for the Supreme Court, dated May 22, 2006. Specifically,

1. The Act imposes no undue burden under Planned Parenthood vs. Casey because there is no substantial, reliable evidence that the Act will increase medical risks for any woman.

2. There is no substantial, reliable evidence that any maternal or fetal condition requires the use of D&X.
3. There is no substantial, reliable evidence that D&X is safer than existing procedures.

Mother's Life Exception

The federal Partial Birth Abortion Ban Act of 2003 contains an express exception "to save the life of a mother, whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-threatening physical condition cause by or arising from the pregnancy itself." The same language is included in Wisconsin Assembly Bill 710.

Evidence-based research reveals that there is no indication for use of this procedure, even in the context of hydrocephaly or other anomalies of the baby or for any condition of the mother. Because of the extreme subjectivity of the lower courts standard of review ("medically necessary to preserve a woman's health") relied entirely on intuition and personal observation, not empirical evidence, the Supreme Court upheld the federal Act. In addition, the terms "medically necessary" and "health" have become terms of art with broad definitions unique to abortion law. The Supreme Court rejected these previously used terms and assessed risks to the mother of an unstudied procedure and the safety of existing procedures. Specifically, the Supreme Court stated that given the availability of other abortion procedures that are considered safe alternatives, the Act is not invalid on it's face where there is uncertainty over whether the barred procedures is ever necessary to preserve the woman's health. The Supreme Court also stated that,

> "Physicians are not entitled to ignore regulations that direct them to use reasonable alternative procedures. The law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community. "

Conclusion

The language contained in the Act covers an express exception which is sufficient to cover a true life-threatening emergency, which exempts from liability physicians acting to save a mother's life. Therefore, I support the federal and Wisconsin's language of a life exception rather than a health exception, based upon the medical evidence.

In recent years, as this procedure has become a contentious issue, I've repeatedly considered whether there is any possible scenario that could justify such a procedure—in other words, any case in which the life of the mother required not simply the termination of the pregnancy but the intentional killing of the infant in the process—and to the best of my knowledge there is none. Yes, sadly there are situations in which a pregnancy can seriously jeopardize or endanger the life of the mother, situations which fall into 4 broad categories (severe cardiac conditions, renal conditions, pregnancy-induced conditions such as toxemia or HELLP syndrome, and cancer); but fortunately with our current technological capabilities these are very rare. However, when they do occur, never—never—does termination of the pregnancy require the intentional destruction and death of the infant. An explanation is in order. In most instances where a "D & X" or partial birth abortion procedure would be utilized, the pregnancy is in the second trimester, or about 2-5 months from term. The labor has to be induced, which is a time consuming process if the uterus is not ready for labor. If the mother's life is truly in danger, one may not have the luxury of such time, necessitating a cesarean section. But having said that, there is something else that you have to understand about preterm deliveries: once the patient is in labor, the delivery is often precipitous. In a term pregnancy, the cervix has to dilate to 10 centimeters, before the second stage, or pushing phase begins. This second stage in a term pregnancy can take anywhere from a few minutes to a few hours. But in a preterm delivery, the cervix only dilates to 3-5 centimeters, depending on the gestational age, and the baby is usually expelled with one push. In order to perform a "partial birth abortion," this precipitous process has to be intercepted and stopped, while the baby is turned to a breech position, its skull punctured, and a suction catheter inserted so that the neural

tissue can be "extracted." So I ask you: if the issue is that the life of the mother is endangered and requires termination of the pregnancy, and if time is of the essence, then why is a precipitous process interrupted with a painful and traumatic intervention that kills the baby, when such termination can occur more quickly by allowing the baby to deliver naturally? The answer: the baby is unwanted. That is the only indication for this barbaric procedure—to make sure that the child is delivered dead. In our modern era of obstetrics, there is no indication for this procedure either for the life or the health of the mother. Therefore, I would challenge any obstetrician to identify one specific situation in which the life of the mother requires not simply the termination of pregnancy, but additionally, the destruction and death of the unborn child.

The "mantra" of medicine these days is that we practice "evidence-based medicine." Everything that we do, every treatment that we utilize is to be backed by sufficient scientific evidence. I would also challenge anyone to provide concrete scientific evidence that supports the safety, efficacy, and necessity of this procedure. To the best of my knowledge, none exists.

In summary, partial birth abortion when used on a living infant, is a barbaric and inhumane procedure that has no medical indication other than to insure that the child is born dead. I urge this committee to support Assembly Bill 710.

Thank you for your time and attention.

STATE OF WISCONSIN
DEPARTMENT OF JUSTICE

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WRITTEN TESTIMONY OF ATTORNEY GENERAL VAN HOLLEN REGARDING 2007 ASSEMBLY BILL 710

January 31, 2008

Chairman Suder and members of the Assembly Committee on Judiciary and Ethics. I am here today for information purposes to discuss the constitutionality of Assembly Bill 710, if enacted as it has been introduced. This bill relates to changes to existing Wisconsin law on partial birth abortions.

While I, or Department of Justice staff, have commented on many bills this session affecting the Department of Justice, criminal justice issues, or public safety issues, it has not been my regular practice to opine on the constitutionality of pending legislation at public hearings. I do so today because I have already provided a written informal opinion relating to the constitutionality of Wisconsin's current partial-birth abortion law.

As many of you may know, Assembly Speaker Michael Huebsch and the Senate Republican Leader, Senator Scott Fitzgerald, previously requested my opinion on the enforceability of 1997 Wisconsin Act 219 and § 940.16 of the Wisconsin Statutes in light of the United States Supreme Court's 2007 decision in *Gonzales v. Carhart*. The *Gonzales* case involved a federal law which defined an unlawful partial birth abortion by reference to a specific act taken by a doctor after fetal delivery to an anatomical land mark.

In *Gonzales*, the Supreme Court held (1) that the federal law was not unconstitutionally vague because it clearly defined the line between criminal conduct and permissible conduct while requiring a clear overt act (the killing of a fetus that has been partially delivered past an objectively identifiable anatomical landmark); (2) that the federal law did not impose an "undue burden" on a woman's right to choose an abortion; and (3) that an exception to criminal liability where necessary to preserve the mother's health was not constitutionally required to be specified in the statute.

My informal opinion to Speaker Huebsch and Senator Fitzgerald on this matter, however, concluded that current Wisconsin law—which may not be enforced today due to a court-ordered injunction—would likely continue to be unenforceable and unconstitutional because current Wisconsin law more closely resembles a Nebraska law found unconstitutional by the Supreme Court in *Stenberg v. Carhart*, rather than the federal law upheld in the *Gonzales* case. The *Stenberg* decision, which was not overruled by the *Gonzales* decision, invalidated the Nebraska law criminalizing partial-birth abortion in part because the law imposed an undue burden on a woman's right to choose a "dilation and evacuation"(D&E) abortion because that law too

broadly defined what constituted a partial birth abortion.

AB 710 is carefully patterned after the federal statute upheld in the *Gonzales* case. In particular, section 7 of the bill, which repeals and recreates § 940.16 of the Wisconsin Statutes, contains a definition of "partial birth abortion" that tracks the approach taken in the federal law upheld in *Gonzales*. The more precise definition of a partial birth abortion in AB 710 as compared to current law makes AB 710 more like the federal law upheld in *Gonzales* rather than the Nebraska law struck down in *Stenberg*. Thus, I believe that AB 710, if enacted as introduced, would survive a constitutional challenge. I provide no opinion as to whether the new law, if enacted, might be found to be unconstitutionally applied against the facts of a specific case.

I have submitted to the Committee a copy of my May 2007 informal opinion, should you wish to review a more thorough discussion of these cases.

I want to be clear that my testimony today is for information only, and I give it to you today in my capacity as Attorney General. My personal beliefs on the topic of abortion are no more relevant to my legal opinion today than they were when I informed Assembly Speaker Huebsch and Senate Republican Leader Fitzgerald that I believed that a court would continue to find current Wisconsin law unconstitutional. I believe that this is how the Attorney General opinion process should work. I provide legal analysis interpreting what the law is and whether it can be enforced. And you, as the state's elected legislative body, determine what the law should be.

I thank the Committee for the opportunity to present this information to you for your consideration as you consider AB 710.

Assembly Bill 710: Partial Birth Abortion Ban
Susan M. Haack, MD, MA, FACOG

Good afternoon. My name is Susan Haack. I am a board-certified obstetrician-gynecologist, with a Master's degree in bioethics from Trinity International University. I attended medical school in Texas (UTMB-Galveston) and did my residency in ob-gyn at Northwestern University in Chicago. I practiced with the Dean Clinic here in Madison before moving to central Pennsylvania where I practiced with my husband for 15 years before returning to Wisconsin. We now practice in Mauston. I am here this afternoon to testify in support of AB 710: the Partial Birth Abortion Ban Act.

While there are indeed certain, but rare, medical conditions that necessitate the premature termination of a pregnancy for the sake of the life the mother, partial birth abortion when used on a living infant has no medical indication other than to insure that the child is born dead. It is merely another means of eliminating an inconvenient life. It is a barbaric and inhumane procedure, which degrades the medical profession and diminishes us as human beings. As such it has no place in the armamentarium of our moral profession and healing art.

I was first introduced to the "D & X" procedure, referred to by many as Partial Birth Abortion, in my residency program in the early 80's but even then it was only of historical interest, being considered an archaic and obsolete procedure which had no place in modern obstetrics. The procedure was originally utilized in an era before the development of routine ultrasonography, electronic fetal monitoring, and safe and effective cesarean sections. Its sole purpose was to effect delivery of a dead, partially birthed, hydrocephalic infant, in order to save the life of the mother, and avoid a cesarean section for a dead infant. To explain, hydrocephalic infants accumulate massive amounts of cerebrospinal fluid in their skulls, causing their soft bones to expand and their heads to

grow far out of proportion to their bodies. Because of the shape of the uterus and maternal pelvis, these unborn infants usually assume a breech position. Before the days of routine ultrasonography, and when breech infants were still delivered vaginally, these infants would deliver in breech position, up to the level of the abdomen or chest, but the enlarged head would get stuck on the maternal pelvic bones, unable to pass into the birth canal. By performing this "D & X" procedure, the fluid in the head could be removed and the baby delivered without having to perform a cesarean section for a dead infant—especially when cesarean sections were not as routine or as safe as they are today. But this was the only indication for this procedure 25 years ago, and is still the only indication for it today. We never used it in our training, in spite of the fact that I distinctly recall one woman whose pregnancy had to be terminated at 20 weeks due to severe atypical toxemia that endangered her life. We delivered her unborn baby by hysterotomy, an incision in the uterus to remove the baby, leaving the uterus intact. While the baby did not survive due to extreme prematurity, we did not intentionally destroy it, nor was there a need to do so.

In the intervening years, I have had only one incident where such a procedure would have been indicated, and it was the exact indication noted above. I was working in a jungle hospital in Gabon, West Africa. A young woman arrived at our hospital from a neighboring hospital 5 hours away with the torso of a dead baby hanging between her legs. With no ultrasound, and not wanting to perform a cesarean section in a primitive hospital for a dead baby, I attempted to place forceps on the head. The forceps had the same effect as a D & X, causing the head of the dead baby to decompress (burst) so the baby could be delivered. That was no doubt life-saving for the mother.